| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 15E594 | A. BUILDING 00<br>B. WING | 06/01/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| MCGIVNEY HEALTH CARE CENTER | 2907 E 136TH ST<br>CARMEL, IN 46033 |

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| F0000 | This visit was for a Recertification and State Licensure survey. This visit included the Investigation of Complaint IN00107420.<br><br>Complaint IN00107420 - Substantiated. Federal/State deficiencies related to the allegation are cited at F223, F225, F226, and F309.<br><br>Survey dates: May 29, 30, 31, and June 1, 2012<br><br>Facility number: 000545<br>Provider number: 15E594<br>AIM number: 100267350<br><br>Survey team:<br>Janet Stanton, R.N.--Team Coordinator<br>Heather Lay, R.N. (5/29, 30, 31)<br>Melanie Strycker, R.N.<br><br>Census bed type:<br>NF--31<br>Total--31<br><br>Census payor type:<br>Medicaid--28<br>Other--3<br>Total--31<br><br>Sample: 10 | F0000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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| | These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.<br><br>Quality review 6/06/12 by Suzanne Williams, RN | | | |

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| F0223 SS=D | 483.13(b), 483.13(b)(1)(i)<br>FREE FROM ABUSE/INVOLUNTARY SECLUSION<br>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.<br><br>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.<br>Based on record review and interview, the facility failed to ensure a resident [Resident #C] was free from physical abuse from another resident [Resident #I]; and failed to ensure a resident [Resident #H] was free from verbal abuse from staff [C.N.A. #3] while residing in the facility. The deficient practice impacted 2 of 4 residents reviewed for allegations of abuse in a sample of 10 residents reviewed.<br><br>Findings include:<br><br>1. Tour of the facility was initiated on 5/29/12 at 10:45 A.M. with the Assistant Director of Nursing [ADoN]. Resident #C was identified as an interviewable quadriplegic with 2 healing stage IV pressure ulcers.<br><br>The Certified Nursing Assistant [CNA] Assignment sheet, no date, was received from the ADoN on 5/29/12 at 12:30 P.M. | F0223 | DisclaimerPreparation, submission and implementation of this Plan of Correction does not constitute an admission of/or agreement with the facts and conclusions set forth on the survey report. McGivney Health Care reserves all rights to contest the survey findings through informal dispute resolution, formal appeal proceedings or any Administrative or legal proceedings. McGivney Health Care reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. The facility offers its responses, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality care to residents. McGivney Health Care reserves the right to modify policies and/or procedures and quality improvement systems as necessary to better meet the needs of the residents and the facility. F223 It is the mission of this facility to provide its residents with a safe and pleasant | 07/01/2012 |

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| | The CNA assignment sheet included, but was not limited to, "[Resident #C] Special Needs: Uses electric wheelchair... quadriplegic..."<br><br>On 5/30/12 at 2:30 P.M., Resident #C's record was reviewed. Diagnoses included, but were not limited to, depression, seizure disorder, traumatic brain injury, and spinal cord injury.<br><br>A "Nurse's Notes" dated 5/27/12, late entry, no time, included, but was not limited to, "Resident's [#C] roommate [Resident #I] attacked resident... no bruising or injuries noted... 15 minute checks initiated, Power of Attorney [POA] and doctor notified..."<br><br>A "Physician's Note" dated 5/29/12, no time, included, but was not limited to, "Chief Complaint: Sustained no injuries after being assaulted by roommate... reports he [Resident #C] was hit on the right upper extremity bilateral... Review of Systems: Spoke with resident today denies any pain, discomfort, or injuries... assessment revealed no bruising, swelling, or injuries..."<br><br>On 5/30/12 at 3:05 P.M., during an interview, Resident #C indicated his roommate [Resident #I] attacked him on 5/27/12, no time given. He indicated the | | environment in which to live. The facility will endeavor to prevent, report the mistreatment, investigate, neglect or abuse of all residents and the misappropriation of property. The facility will not tolerate verbal, mental, sexual or physical abuse, corporal punishment or involuntary seclusion, nor will it allow any staff member to punish a resident at any time during a resident's stay in this facility. MHCC reported these allegations to ISDH. Resident C and Resident I were immediately separated. Residents C and I were immediately assessed and found without injury. Resident I was immediately moved to another room. Staff were present with both residents during and throughout the incident until Resident I was moved to another room and then put on 15minute checks. Both residents were referred to psych. services and seen by psychiatrist next visit.Resident H and CNA-3 were immediately separated by other staff in the facility. The CNA-3 was taken off schedule and terminated. Resident H did not recall the incident. No other residents were affected by this practice.The Facility's Abuse Policy and Procedure was reviewed and revised. All staff are responsible to stop abuse and report abuse immediately. Staff in-service on MHCC ABUSE PREVENTION POLICY AND | |

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| | nurse [LPN #2] was present when the abuse occurred. Resident #C indicated his roommate was upset at him related to the temperature in the room. Resident #C indicated Resident #I attacked him and punched his right leg. He indicated the nurse [LPN #2] got between him and Resident #I and was knocked down. Resident #C indicated Resident #I was then calmed down after approximately 2 minutes and placed in bed. Resident #C indicated Resident #I was moved out of their room. He denied feeling fearful of Resident #I. Resident #C indicated staff checked on him a lot.<br><br>On 5/30/12 at 4:00 P.M., in an interview, the Administrator indicated she was aware of the incident and would provide her investigation to date of the incident.<br><br>On 5/31/12 at 12:45 P.M., the Administrator provided a document titled, "Investigative Report for Suspected Abuse, Neglect, or Unusual Occurrence" [an investigative narrative] dated 5/31/12.<br><br>The investigative narrative included, but was not limited to, "On 5/27/12 around 4:45 P.M. to 5:00 P.M., LPN #2 contacted the [DoN] to report a resident to resident altercation between [Resident #C and Resident #I]... LPN #2 said she put a CNA [CNA #1] one on one with Resident | | PROCEDURE (JUNE 2012) by the SSD/DON. All new employees will receive and be in-serviced on the MHCC ABUSE PREVENTION POLICY AND PROCEDURE (JUNE 2012) upon hire. The DON/designee is the Abuse Investigation Coordinator and will be responsible for utilizing the revised INVESTIGATIVE REPORT FOR SUSPECTED ABUSE, NEGLECT, OR UNUSUAL OCCURRENCE (JUNE 2012). The Quality Assurance Committee will monitor compliance of the facility MHCC ABUSE PREVENTION POLICY AND PROCEDURE for each incident and on a quarterly basis. | |

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| | #I [alleged violator]... On 5/27/12 reportable sent to ISDH..."<br><br>On 5/31/12 at 2:35 P.M., in an interview, CNA #1 indicated he was called to Resident #C and Resident #I's room by LPN #2. At that time, LPN #2 indicated to CNA #1 that Resident #I was beating Resident #C [prior to his arrival to the room]. CNA #1 indicated both residents were resting when he entered the room; however, he stayed in the room to monitor until LPN #2 returned. Upon her return, CNA #1 was instructed to stay with Resident #I until Resident #I was moved to a different room. CNA #1 indicated Resident #I was cooperative the rest of his shift.<br><br>The facility abuse policy and procedures were followed regarding the witnessed physical abuse of Resident #C from Resident #I.<br><br>2. On 5/31/12 at 10:40 A.M., Resident #I's record was reviewed. Diagnoses included, but were not limited to, anxiety, aphasia, hemiplegia non-dominant side, and cerebral vascular accident.<br><br>A "Nurse's Notes" dated 5/27/12 at 4:30 P.M., included, but was not limited to, "Resident [I] notified this nurse [LPN #2] that room too cold... Resident [I] angry... | | | |

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| | Resident [C] complaining it was too hot... Resident [I] pushed this nurse [LPN #2] onto roommate's [Resident #C] bed and started hitting this nurse [LPN #2] and roommate [Resident #C]..."<br><br>There was no other documentation of aggressive behavior in Resident #I's record.<br><br>On 5/31/12 at 2:45 P.M., in an interview, the Administrator indicated Resident #I was not physically aggressive with other residents or staff members.<br><br>The resident was removed from the situation, placed on one to one observation with CNA #1 then moved to another room and placed on 15 minute checks.<br>3. Following the entrance conference on 5/29/12 at 10:30 A.M., the Administrator provided the investigation the facility completed for an incident involving Resident #H and C.N.A. #3.<br><br>The facility's investigation documentation indicated that on 4/2/11, C.N.A. #3 was overheard by the Charge Nurse and another C.N.A. to "yell" at Resident #H.<br><br>The incident was reported to the Administrator and ISDH Division of Long Term Care as required. | | | |

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| | The follow-up investigation indicated [Resident #H] was trying to use the phone at 11:00 P.M. to call 911, and the C.N.A. tried to prevent her from doing so. The C.N.A. "admitted she argued in a raised voice and pointed her finger in [Resident #H]'s face." The C.N.A. also "reported she was over-stressed at work, and if her hours were not reduced (Saturday off), she might do it again."<br><br>The C.N.A. was immediately suspended during the investigation, and was subsequently terminated from employment at the facility. A follow-up abuse prevention in-service was given to all other staff.<br><br>This Federal tag relates to Complaint IN00107420.<br><br>3.1-27(a)(1)<br>3.1-27(b) | | | |

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| F0225 SS=D | 483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS<br>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.<br><br>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).<br><br>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.<br><br>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. | | | |
| | Based on interview and record review, the facility failed to thoroughly investigate, or | F0225 | DisclaimerPreparation, submission and implementation of this Plan of Correction does not | 07/01/2012 |

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| | report to ISDH Division of Long Term Care immediately, one allegation of neglect [Resident #K] and one allegation of misappropriation of property [Resident #C], for 2 of 4 residents reviewed for allegations of abuse; in a sample of 10 residents reviewed.<br><br>Findings include:<br><br>Following the entrance conference on 5/29/12 at 10:30 A.M., the Administrator provided the investigations the facility completed for 3 allegations of abuse since the last annual survey on 3/18/11.<br><br>A. One of the investigations the facility provided for review involved Resident #K, who alleged that "no one had let her eat or drink all day."<br><br>The "Investigative Report for Suspected Abuse, Neglect, or Unusual Occurrence" form was dated as completed by the Social Service Director on 2/15/12, and indicated the following:<br><br>"Date and Time of Occurrence: February 10, 2012 [no time was listed]<br><br>Documentation of Complaint/Occurrence: Resident stated to SSD [Social Service Director] that on Saturday, February 11, 2012--no one let her eat or drink all day. | | constitute an admission of/or agreement with the facts and conclusions set forth on the survey report. McGivney Health Care reserves all rights to contest the survey findings through informal dispute resolution, formal appeal proceedings or any Administrative or legal proceedings. McGivney Health Care reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. The facility offers its responses, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality care to residents. McGivney Health Care reserves the right to modify policies and/or procedures and quality improvement systems as necessary to better meet the needs of the residents and the facility.F 225 It is the mission of this facility to provide its residents with a safe and pleasant environment in which to live. The facility will endeavor to prevent, investigate, report the mistreatment, neglect or abuse of all residents and the misappropriation of property. The facility will not tolerate verbal, mental, sexual or physical abuse, corporal punishment or involuntary seclusion, nor will it allow any staff member to punish a resident at any time during a resident's stay in this facility.The facility immediately investigated | |

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| | Interview and Witness(es)/Staff member(s)/Residents: SSD and Administrator reviewed cameras that showed the resident did eat at meal times.<br><br>Follow-Up Action Taken: Spoke with the resident and explained that we viewed the tapes and she was eating/drinking at all meal times.<br><br>Reported to ISDH or Other Officials in Accordance to State Law: No"<br><br>In an interview on 5/31/12 at 3:10 P.M., the Social Service Director indicated the resident came to her on 2/15/12 "sometime in the morning"--she did not know exactly when, and reported the incident. The resident did not give her any specific time frame that the incident occurred, and the SSD did not probe for anything further. After the resident reported the incident, the SSD went to talk to the staff about the incident, and reported to the Administrator. She had not documented, nor did she remember, what time she spoke with staff, and had not kept documentation of which staff she interviewed, but all interviews were done "that morning." The SSD also indicated the camera monitoring tapes were "reviewed that morning." | | both unsubstantiated allegations from Resident K and Resident C the day they were reported to the SSD. The facility failed to report the unsubstantiated allegations to ISDH.No other residents were affected by this practice. The facility will immediately report to ISDH, all allegations of neglect or misappropriation of property from all residents whether substantiated or unsubstantiated. The Facility's Abuse Policy and Procedure was reviewed and revised. The Facility's INVESTIGATIVE REPORT FOR SUSPECTED ABUSE, NEGLECT, OR UNUSUAL OCCURRENCE (JUNE 2012) form was revised. All Staff in-service conducted on: MHCC ABUSE PREVENTION POLICY AND PROCEDURE (JUNE 2012) and Reporting all Allegation of Abuse (F225 and F226)All staff are responsible to stop abuse and report abuse immediately. Staff in-service on MHCC ABUSE PREVENTION POLICY AND PROCEDURE (JUNE 2012) and Reporting all Allegation of Abuse (F225 and F226) was conducted in June 2012 by the SSD/DON. All new employees will receive and be in-serviced on the MHCC ABUSE PREVENTION POLICY AND PROCEDURE (JUNE 2012) upon hire. The DON/designee is the Abuse Investigation Coordinator and will be responsible for utilizing the revised INVESTIGATIVE | |

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| | In an interview at that time, the Administrator indicated the incident was not reported to ISDH because they had reviewed the camera tapes and had determined the resident had eaten at all meals.<br><br>B. The second investigation involved Resident #C who alleged the Maintenance Supervisor took his Blue Tooth device.<br><br>The "Investigative Report for Suspected Abuse, Neglect, or Unusual Occurrence" form was dated as completed by the Social Service Director on 3/15/12, and indicated the following:<br><br>"Date and Time of Occurrence: March 13, 2012 [no time was listed].<br><br>Documentation of Complaint/Occurrence: Resident reported to CNA that Blue Tooth was stolen by staff--Maintenance man.<br><br>Interview with Witness(es)/Staff member(s)/Residents: Spoke with [Maintenance Supervisor]--he never saw the Blue Tooth. Only was in room to program the remote control.<br><br>Spoke with [C.N.A.]-- [There was no documentation of the interview information] | | REPORT FOR SUSPECTED ABUSE, NEGLECT, OR UNUSUAL OCCURRENCE (JUNE 2012). The Quality Assurance Committee will monitor compliance of the facility MHCC ABUSE PREVENTION POLICY AND PROCEDURE for each incident on a quarterly basis. | |

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| | Resident moved here on 2/27/12--at that time he did not have his Blue Tooth for his phone. SSD asked him about it and why he did not have it in his ear. Resident stated he did not want to use it. SSD asked him where it was, he stated he did not know. It was not listed on his inventory sheet at admission. P.O.A. [Power of Attorney] called and told SSD he did not have a Blue Tooth and has not had one for weeks. P.O.A. was purchasing a new Blue Tooth and would bring it in.<br><br>Reported to ISDH or Other Officials in Accordance to State Law: No"<br><br>In an interview on 5/31/12 at 3:20 P.M., the Social Service Director indicated the resident requested to see her on 3/15/12, and reported the device was missing on 3/13/12. She interviewed the C.N.A. on 3/15/12, who did not remember when the resident told her about the missing device--only that he accused the Maintenance supervisor. The C.N.A. reported she only saw the device once on the night stand, but no date was given.<br><br>The date and time the P.O.A. was contacted was not documented.<br><br>In an interview at that time, the | | | |

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| | 15E594 | A. BUILDING 00<br>B. WING | 06/01/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| MCGIVNEY HEALTH CARE CENTER | 2907 E 136TH ST<br>CARMEL, IN 46033 |

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| | Administrator indicated the allegation was not reported to ISDH because they had determined, after speaking with the P.O.A., that the resident had not had a Blue Tooth device.<br><br>This Federal tag relates to Complaint IN00107420.<br><br>3.1-28(c)<br>3.1-28(d) | | | |

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| F0226 SS=D | 483.13(c)<br>DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES<br>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.<br>Based on interview and record review, the facility failed to fully implement their Abuse Prevention procedures, related to investigation and reporting allegations, for 2 of 4 allegations reviewed; for Residents #K and #C.<br><br>Findings include:<br><br>1. Following the entrance conference on 5/29/12 at 10:30 A.M., the Administrator provided the investigations the facility completed for 3 allegations of abuse since the last annual survey on 3/18/11.<br><br>A. One of the investigations the facility provided for review involved Resident #K, who alleged that "no one had let her eat or drink all day."<br><br>The "Investigative Report for Suspected Abuse, Neglect, or Unusual Occurrence" form was dated as completed by the Social Service Director on 2/15/12, and indicated the following:<br><br>"Date and Time of Occurrence: February | F0226 | DisclaimerPreparation, submission and implementation of this Plan of Correction does not constitute an admission of/or agreement with the facts and conclusions set forth on the survey report. McGivney Health Care reserves all rights to contest the survey findings through informal dispute resolution, formal appeal proceedings or any Administrative or legal proceedings. McGivney Health Care reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. The facility offers its responses, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality care to residents. McGivney Health Care reserves the right to modify policies and/or procedures and quality improvement systems as necessary to better meet the needs of the residents and the facility.F 226 It is the policy of the facility to fully implement their Abuse Prevention Procedures related to investigations and reporting allegations. It is the mission of this facility to provide | 07/01/2012 |

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| | 10, 2012 [no time was listed]<br><br>Documentation of Complaint/Occurrence: Resident stated to SSD [Social Service Director] that on Saturday, February 11, 2012--no one let her eat or drink all day.<br><br>Interview and Witness(es)/Staff member(s)/Residents: SSD and Administrator reviewed cameras that showed the resident did eat at meal times.<br><br>Follow-Up Action Taken: Spoke with the resident and explained that we viewed the tapes and she was eating/drinking at all meal times.<br><br>Reported to ISDH or Other Officials in Accordance to State Law: No"<br><br>In an interview on 5/31/12 at 3:10 P.M., the Social Service Director indicated the resident came to her on 2/15/12 "sometime in the morning"--she did not know exactly when, and reported the incident. The resident did not give her any specific time frame that the incident occurred, and the SSD did not probe for anything further. After the resident reported the incident, the SSD went to talk to the staff about the incident, and reported to the Administrator. She had not documented, nor did she remember, what time she spoke with staff, and had | | its residents with a safe and pleasant environment in which to live. The facility will endeavor to prevent, report the mistreatment, neglect or abuse of all residents and the misappropriation of property. The facility will not tolerate verbal, mental, sexual or physical abuse, corporal punishment or involuntary seclusion, nor will it allow any staff member to punish a resident at any time during a resident's stay in this facility.The facility immediately investigated both unsubstantiated allegations from Resident K and Resident C the day they were reported to the SSD. The facility but failed to report the unsubstantiated allegations to ISDH.No other residents were affected by this practice. The facility will immediately implement the Abuse Prevention procedures, related to investigation and reporting allegations to the ISDH, all allegations of neglect or misappropriation of property from all residents whether substantiated or unsubstantiated. The Facility's Abuse Policy and Procedure was reviewed and revised.The Facility's INVESTIGATIVE REPORT FOR SUSPECTED ABUSE, NEGLECT, OR UNUSUAL OCCURRENCE (JUNE 2012) form was revised.All Staff in-service conducted on: MHCC ABUSE PREVENTION POLICY AND PROCEDURE (JUNE 2012) | |

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| | not kept documentation of which staff she interviewed, but all interviews were done "that morning." The SSD also indicated the camera monitoring tapes were "reviewed that morning."<br><br>In an interview at that time, the Administrator indicated the incident was not reported to ISDH because they had reviewed the camera tapes and had determined the resident had eaten at all meals.<br><br>B. The second investigation involved Resident #C who alleged the Maintenance Supervisor took his Blue Tooth device.<br><br>The "Investigative Report for Suspected Abuse, Neglect, or Unusual Occurrence" form was dated as completed by the Social Service Director on 3/15/12, and indicated the following:<br><br>"Date and Time of Occurrence: March 13, 2012 [no time was listed].<br><br>Documentation of Complaint/Occurrence: Resident reported to CNA that Blue Tooth was stolen by staff--Maintenance man.<br><br>Interview with Witness(es)/Staff member(s)/Residents: Spoke with [Maintenance Supervisor]--he never saw | | and Reporting all Allegation of Abuse (F225 and F226)All staff are responsible to stop abuse and report abuse immediately. Staff in-service on MHCC ABUSE PREVENTION POLICY AND PROCEDURE (JUNE 2012) and Reporting all Allegation of Abuse (F225 and F226) was conducted in June 2012 by the SSD/DON. All new employees will receive and be in-serviced on the MHCC ABUSE PREVENTION POLICY AND PROCEDURE (JUNE 2012) upon hire. The DON/designee is the Abuse Investigation Coordinator and will be responsible for utilizing the revised INVESTIGATIVE REPORT FOR SUSPECTED ABUSE, NEGLECT, OR UNUSUAL OCCURRENCE (JUNE 2012). The Quality Assurance Committee will monitor compliance of the facility MHCC ABUSE PREVENTION POLICY AND PROCEDURE for each incident and on a quarterly basis. | |

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| | the Blue Tooth. Only was in room to program the remote control.<br><br>Spoke with [C.N.A.]-- [There was no documentation of the interview information]<br><br>Resident moved here on 2/27/12--at that time he did not have his Blue Tooth for his phone. SSD asked him about it and why he did not have it in his ear. Resident stated he did not want to use it. SSD asked him where it was, he stated he did not know. It was not listed on his inventory sheet at admission. P.O.A. [Power of Attorney] called and told SSD he did not have a Blue Tooth and has not had one for weeks. P.O.A. was purchasing a new Blue Tooth and would bring it in.<br><br>Reported to ISDH or Other Officials in Accordance to State Law: No"<br><br>In an interview on 5/31/12 at 3:20 P.M., the Social Service Director indicated the resident requested to see her on 3/15/12, and reported the device was missing on 3/13/12. She interviewed the C.N.A. on 3/15/12, who did not remember when the resident told her about the missing device--only that he accused the Maintenance supervisor. The C.N.A. reported she only saw the device once on | | | |

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| | the night stand, but no date was given.<br><br>The date and time the P.O.A. was contacted was not documented.<br><br>In an interview at that time, the Administrator indicated the allegation was not reported to ISDH because they had determined, after speaking with the P.O.A., that the resident had not had a Blue Tooth device.<br><br>2. On 5/31/12, the Assistant Director of Nursing provided a two-page paper, not dated, titled "Abuse Policy" and a one-page paper, not dated, titled "Abuse Policy and Procedure (Including Elder Justice Act)." She indicated these were the current policies and procedures.<br><br>The procedures included, but were not limited to, the following:<br><br>"... 1. The problem or concern will be investigated immediately and corrective actions taken for resident safety....<br><br>5. The Social Service Director and the Administrator will complete documentation in the INVESTIGATIVE REPORT FOR SUSPECTED ABUSE, NEGLECT, OR UNUSUAL OCCURRENCE form by investigating the situation and talking to involved | | | |

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| | individuals....<br><br>6. Allegations will be investigated in accordance with State Law....<br><br>7. The Administrator/designee will be responsible to complete a REPORTABLE UNUSUAL OCCURRENCE form within 24 hours of occurrence and send to the ISDH...."<br><br>This Federal tag relates to Complaint IN00107420.<br><br>3.1-28(a) | | | |

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| F0309 SS=D | 483.25<br>PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.<br><br>Based on record review and interview, the facility failed to properly assess the lung sounds of 2 of 2 residents [Residents #B and #J] who were prescribed antibiotics for lung conditions; in a sample of 10 residents reviewed.<br><br>Findings include:<br><br>1. On 5/29/12, tour of the facility was initiated with the ADoN [Assistant Director of Nursing] at 10:45 A.M. She identified Resident #B as non-compliant with care and required oxygen therapy.<br><br>On 5/30/12 at 10:00 A.M., Resident #B's record was reviewed. Diagnoses included, but were not limited to, hypertension, diabetes mellitus type I, congestive heart failure, and edema.<br><br>A "Condition Change Form" dated 3/23/12, no time, included, but was not limited to, "Status Change: Amoxicillin 500 milligrams daily for 10 days..." | F0309 | DisclaimerPreparation, submission and implementation of this Plan of Correction does not constitute an admission of/or agreement with the facts and conclusions set forth on the survey report. McGivney Health Care reserves all rights to contest the survey findings through informal dispute resolution, formal appeal proceedings or any Administrative or legal proceedings. McGivney Health Care reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. The facility offers its responses, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality care to residents. McGivney Health Care reserves the right to modify policies and/or procedures and quality improvement systems as necessary to better meet the needs of the residents and the facility.F309 Resident #B and Resident # J Lung conditions are resolved and are no longer on antibiotics. Resident #B & | 07/01/2012 |

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| | A "Medication Administration Record" [MAR], dated 3/23/12, included, but was not limited to, "Amoxicillin 500 milligrams by mouth three times per day for 10 days... Doses were marked as given starting 3/23/12 through 4/3/12..."<br><br>A "Day Follow-Up Charting" dated with a start date of 3/25/12 and end date of 3/31/12, included, but was not limited to, "Reason: Antibiotics for upper respiratory infection [URI]... Monitor for signs and symptoms of temperature and breath sounds..."<br><br>Temperature was charted; however, no assessment of Resident #B's lung sounds were documented in the clinical record for 4 days during antibiotic therapy from 3/23/12 to 3/27/12.<br><br>On 3/27/12, no time, a "Nursing Assessment" included, but was not limited to, "Lungs sounds clear bilaterally..."<br><br>The next assessment of lung sounds was 7 days later on 4/3/12, the last day of antibiotic therapy.<br><br>On 5/31/12 at 12:00 P.M., in an interview, the ADoN indicated she did not have any other documentation to provide regarding lung assessments on | | Resident # J have not had a negative outcome related to their “lung conditions”. All residents have the potential to be affected. There are currently no residents with “lung conditions” at this time. All residents who have ATB therapy related to “lung conditions”/ URI will been monitored every shift by charge nurse during course of ATB with interventions as indicated in the facility's follow up documentation guidelines. Nursing staff has been re-educated on the facility's documentation guidelines for “Lung conditions”/URI.The DON is responsible for the re-educating the Charge Nurses on the facility's documentation guidelines for “Lung conditions”/URI by July 1, 2012. To ensure compliance, The DON or designee will monitor for compliance utilizing facility audit tool weekly times 4 weeks, bi-monthly times for 2 months and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. | |

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| | Resident B. She indicated it is the expectation of the nurses to document lung sounds when a resident was treated for a lung condition.<br><br>2. On 5/29/12, tour of the facility was initiated with the ADoN [Assistant Director of Nursing] at 10:45 A.M. During the tour, she identified Resident #J as non-interviewable with dementia, behaviors, and pain.<br><br>On 5/31/12 at 9:50 A.M., Resident #J's record was reviewed. Diagnoses included, but were not limited to, chronic pain, bipolar, diabetes mellitus type II, dementia, and gout.<br><br>A 'Nurse's Notes" dated 2/7/12 at 2:30 P.M., included, but was not limited to, "Resident [#J] complained of ribs hurting... resident sent to emergency room..."<br><br>A "Condition Change Form" dated 2/7/12 at 10:50 P.M., included, but was not limited to, "Started on antibiotic, Azithromycin 500 milligrams now, then 250 milligrams every day for 4 days..."<br><br>A "Condition Change Form" dated 2/8/12, no time, included, but was not limited to, "Follow-up chest x-ray from 2/7/12 with diagnosis of pneumonia..." | | | |

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| | A "Day Follow-Up Charting" with the start date of 2/8/12 through 2/20/12, included, but was not limited to, "Reason: Antibiotic Therapy... Monitor for signs and symptoms of: Adverse Reaction, lung sounds..."<br><br>There was no lung assessment found in Resident #J's record for 4 days from 2/8/12 through 2/11/12.<br><br>A "Physician's Progress Notes" dated 2/12/12, no time, included, but was not limited to, "History of present illness: complains of right chest discomfort... Review of systems: lungs: diminishing..."<br><br>A "Condition Change Form" dated 2/12/12, no time, included, but was not limited to, "[Resident #J] sent to the emergency room for evaluation and treatment for chest pain and crackles in lungs... Doxycycline 100 milligrams by mouth 2 times per day for 10 days..."<br><br>There was no lung assessment found in Resident #J's record for 2/13/12.<br><br>A "Condition Change Form" dated 2/14/12, no time, included, but was not limited to, "Nurse Practitioner visited with resident... new order for follow-up | | | |

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| | chest x-ray..."<br><br>There were no lung assessments for the last 4 days of antibiotic therapy from 2/16/12 through 2/20/12.<br><br>On 5/31/12 at 12:00 P.M., in an interview, the ADoN indicated she did not have any further documentation regarding the lung assessments for Resident #J.<br><br>This Federal tag relates to Complaint IN00107420.<br><br>3.1-37(a) | | | |

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| F0329 SS=D | 483.25(l)<br>DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS<br>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.<br><br>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. | | | |
| | Based on interview and record review, the facility failed to properly monitor 1 of 1 resident who was receiving Coumadin [blood thinner] therapy for signs and symptoms of bleeding; in a sample of 10 residents reviewed. [Resident #25]<br><br>Findings include:<br><br>The clinical record for Resident #25 was reviewed on 5/30/12 at 10:55 A.M. Diagnoses included, but were not limited to, atrial fibrillation on chronic | F0329 | DisclaimerPreparation, submission and implementation of this Plan of Correction does not constitute an admission of/or agreement with the facts and conclusions set forth on the survey report. McGivney Health Care reserves all rights to contest the survey findings through informal dispute resolution, formal appeal proceedings or any Administrative or legal proceedings. McGivney Health Care reserves all rights to raise all possible contentions and defenses in any type of civil or | 07/01/2012 |

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| | 15E594 | A. BUILDING 00<br>B. WING | 06/01/2012 |

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| | anticoagulant therapy, dementia, and history of a C.V.A. [cerebral vascular accident--"stroke"] with right upper extremity hemiparesis [paralysis].<br><br>The May 2012 physician order recap [recapitulation] sheet listed an order, dated 2/2/12, for a PT/INR [Prothrombin Time/International Normalized Ratio] blood test every Monday and Thursday. A normal Prothrombin time range is 10-14 seconds, and an INR therapeutic range is 2.0-3.0 for a person receiving anticoagulant medication. The resident also had physician orders for Coumadin, with doses ranging from 5.0 to 6.0 mg. [milligrams] daily, based on current PT/INR lab results.<br><br>On 3/26/12, the PT/INR was 34.1 / 3.29. On 3/27/12, the physician gave an order to hold the Coumadin for 2 days and resume the current dose of 5.5 mg. on 3/29/12.<br><br>There was no documentation/evidence in the clinical record that licensed nursing staff were actively checking the resident for any signs/symptoms of bleeding on the days the anti-coagulant was held.<br><br>On 4/9/12, the PT/INR was 31.1 / 3.0. On 4/10/12 the physician gave an order to hold the Coumadin for 2 days and resume | | criminal claim, action or proceeding. The facility offers its responses, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality care to residents. McGivney Health Care reserves the right to modify policies and/or procedures and quality improvement systems as necessary to better meet the needs of the residents and the facility.F329Resident #25 has had no further incidents of bruising or bleeding since survey. PT/INR"s has been reviewed per MD 3 times per week with Coumadin adjustments as necessary per physician order.Any residents on Coumadin/Warfarin have potential to be affected. All residents who have a critical PT/ INR secondary to Coumadin/ Warfarin therapy will be monitored every shift until non critical PT/INR is obtained.Nursing staff has been re-educated on the facility's documentation and assessments for critical lab values related Coumadin /Warfarin therapy.The DON is responsible to re-educate the Charge Nurses on the facility's documentation and assessments for critical lab values related Coumadin /Warfarin therapy by July 1, 2012. To ensure compliance, The DON or designee will monitor for compliance utilizing facility audit tool weekly times 4 weeks, bi-monthly times 2 months, and | |

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| | on 4/12/12.<br><br>There was no documentation/evidence in the clinical record that licensed nursing staff were actively checking the resident for any signs/symptoms of bleeding on the days the anti-coagulant was held.<br><br>On 4/23/12, the PT/INR was 46.2 / 4.49. On 4/23/12 the physician gave an order to hold the Coumadin on 4/23 and 4/25, and repeat the PT/INR on 4/25.<br><br>There was no documentation/evidence in the clinical record that licensed nursing staff were actively checking the resident for any signs/symptoms of bleeding on the days the anti-coagulant was held.<br><br>On 4/30/12, the PT/INR was 62.0 / 6.06. On 4/30/12, the physician gave an order to give Vitamin K immediately by intramuscular injection, and hold the Coumadin until further notice.<br><br>On 4/30/12, a "___ DAY/HOUR FOLLOW-UP ASSESSMENT CHARTING" form was initiated. The form indicated "REASON: Critical PT IN [sic] MONITOR FOR S/S [signs/symptoms] OF: Bleeding, bruising, petechiae, edema." There was documentation for each shift from 4/30 through 5/5/12. | | then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QA committee overseen by the ED. | |

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| | In an interview on 5/31/12 at 9:30 A.M., the Assistant Director of Nursing indicated she had just formulated and initiated the Assessment Charting forms. She indicated she was unable to find any other documentation that demonstrated licensed nursing staff were monitoring for signs/symptoms of bleeding for the episodes of elevated PT/INR prior to the 4/30/12 episode.<br><br>3.1-48(a)(3) | | | |

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| F0371 SS=F | 483.35(i)<br>FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY<br>The facility must -<br>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and<br>(2) Store, prepare, distribute and serve food under sanitary conditions<br><br>Based on observation, interview and record review, the facility failed to label food to indicate the date it was made or a "use-by" date; and failed to maintain equipment in a clean, sanitary manner in 1 of 1 kitchen and 1 of 1 kitchenette. These deficient practices had the potential to affect 31 of 31 residents who ate meals from the kitchen.<br><br>Findings include:<br><br>1. During the initial observation of the kitchen on 5-29-12 at 10:25 A.M., a plate in the reach-in refrigerator was observed to contain 4 sandwiches covered with plastic wrap. No label was present. On the same shelf was a 6 X 6 X 8 inch plastic container containing food without a label. On the counter to the left of the double sink was a baking tray containing a food item covered with plastic wrap. This item did not contain a label.<br><br>During an interview at this same time, the Dietary Manager indicated the unlabeled | F0371 | DisclaimerPreparation, submission and implementation of this Plan of Correction does not constitute an admission of/or agreement with the facts and conclusions set forth on the survey report. McGivney Health Care reserves all rights to contest the survey findings through informal dispute resolution, formal appeal proceedings or any Administrative or legal proceedings. McGivney Health Care reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. The facility offers its responses, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality care to residents. McGivney Health Care reserves the right to modify policies and/or procedures and quality improvement systems as necessary to better meet the needs of the residents and the facility.F371The Dietary Manager immediately threw away all unlabeled food/drinks in the kitchen and kitchenette. The Dietary Manager immediately | 07/01/2012 |

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| | items in the refrigerator were chicken salad sandwiches and chicken salad, and the unlabeled food next to the sink was a tray of lemon bars.<br><br>2. A shelf above the stove contained three large skillets stored as clean. One of three skillets was observed to contain greasy food residue. The skillet handle felt greasy to touch. | | removed the soiled skillet from the stove and placed in the sink to be washed. The skillets identified were cleaned, sanitized, and air-dried and appropriately stored. The Dietary Manager immediately re-trained the new employee to label food and the sanitation requirements regarding kitchen equipment food-contact surfaces and utensils. The kitchenette refrigerator was immediately defrosted and sanitized.All residents have the potential to be affected.The Facility's Labeling Policy and Procedure was reviewed and revised. All dietary staff were in-service on the Labeling Policy and Procedure and the Sanitation Requirements regarding kitchen equipment food-contact surfaces and utensils. The Nursing Defrost Schedule and the Defrost Schedule form was revised. Nursing staff were in-serviced on the Kitchenette Defrost Schedule and the Defrost Schedule form.The Dietary staff are responsible for labeling food in the kitchen/kitchenette/and on proper location to put kitchen equipment to be cleaned. The Dietary Manager is responsible to monitor the dietary staff 4xs a week to ensure all food is labeled and maintaining sanitation requirements and report findings to ED 4 weeks, bi-monthly times 2 months, and then quarterly until continued compliance is maintained for 2 consecutive | |

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| | | | quarters. The housekeeping staff are responsible to sanitize the inside kitchenette refrigerator daily. The CNAs are responsible for weekly defrosting the Kitchenette refrigerator and completing the Defrost Schedule form. The Charge Nurses are responsible to ensure the CNAs defrost the refrigerator and complete the Defrost Schedule form. The DON is responsible for ensuring the defrost schedule is completed by CNAs/Charge Nurses and the Defrost Schedule form is completed. The DON or designee will monitor for compliance utilizing facility audit tool weekly times 4 weeks, bi-monthly times 2 months, and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QA committee overseen by the ED. | |
| | 3. The Environmental tour task was done on 5/31/12 at 9:15 A.M., with the Maintenance Supervisor and the Administrator in attendance.<br><br>The following was observed in the combination refrigerator/freezer located in the kitchenette in the corner of the dining room:<br><br>A. One plate with 2 sandwiches, covered with clear plastic wrap. Each appeared to have a slice of ham and cheese; however | | | |

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| | there was no label on the plastic wrap to indicate what it was, and there was no date to indicate when the sandwiches had been made or the date by which they were to be used/consumed.<br><br>A second plate with 2 sandwiches, covered with clear plastic wrap. Each appeared to have peanut butter with jelly; however there was no label on the plastic wrap to indicate what it was, and there was no date to indicate when the sandwiches had been made or the date by which they were to be used/consumed.<br><br>One 240-ounce Styrofoam cup half full of a red liquid. A piece of clear plastic wrap was loosely wrapped over the top of the cup. There was no label on the cup or the plastic wrap to identify what it was; and there was no date to indicate when it had been prepared or a date by which it was to be used/consumed.<br><br>In an interview at that time, the Administrator indicated the Dietary Manager had been on vacation, and a new Dietary department employee had been in charge. The new employee had not been aware that food items needed to be labeled and dated.<br><br>B. The small freezer compartment had no closing door, and had an inch build-up of | | | |

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| | frost around the inside and outside walls of the compartment. Part of the frost had a dark brown color. In an interview at that time, the Maintenance Director and Administrator indicated it looked like someone had left a soda pop in the freezer and it had "exploded," spilling the soda in the freezer and then freezing it.<br><br>The Administrator indicated the freezer was scheduled to be defrosted on Mondays, but "something had happened."<br><br>In an interview on 5/31/12 at 10:15 A.M., the Assistant Director of Nursing indicated nursing department was responsible for defrosting the freezer compartment twice a month. On 6/1/12, she provided a sheet of paper titled "Defrosting the Refrigerators" which was revised on 2/1/12. The paper indicated "Refrigerators need to be defrosted on the 1st. and 15th of every month by 3rd. shift C.N.A.s." A check-list was marked for the 1st. and 15th. of May.<br><br>4. The "Retail Food Establishment Sanitation Requirements, Title 410 IAC 7-24" effective 11/13/04 indicated the following:<br><br>"SEC 191. (a) Except as specified in subsection (d), refrigerated, ready-to-eat, potentially hazardous food prepared and | | | |

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| | held in a retail food establishment for more than twenty-four (24) hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on one (1) of the temperature and time combinations specified as follows and the day of preparation shall be counted as day one (1):...."<br><br>and<br><br>"SEC 295. (a) Equipment food-contact surfaces and utensils shall be clean to sight and touch. (b) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations...."<br><br>3.1-21(i)(3) | | | |